

Medicare Prescription Drug Coverage

“General Information about Standard Benefits”



A 2007 Guide Produced by the CHOICES Program

On January 1, 2006, Medicare began a new program to pay for prescription drugs for everyone who has Medicare Part A and/or Part B. This Guide will give you information about the program and help you decide whether you want to enroll. **It also provides information of importance to Medicare-eligible employees, retirees and their dependents who currently have prescription drug coverage through an employer or union.**

IMPORTANT: If you have or are eligible for Medicaid (Title 19), a Medicare Savings Program (QMB, SLMB, or ALMB), or ConnPACE, please ask your CHOICES counselor for the special Guides that describe how these programs work with the Medicare prescription drug program. The information in this Guide may not apply to those groups of people. If you want to know about getting “Extra Help” to pay for Medicare prescription drug coverage, ask CHOICES for a copy of the Extra Help Guide.

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1. **What is Medicare prescription drug coverage?**

On January 1, 2006, Medicare began a new program to pay for most outpatient prescription drugs, insulin and insulin supplies, and “stop smoking” drugs. It is a program for everyone who has Medicare. It is also known as “Medicare Rx” and “Medicare Part D.”

The Medicare prescription drug program is voluntary. **Not everyone needs to or should enroll!**

For example, people who have existing “creditable” insurance should not enroll without first checking with their current plan’s Benefits Administrator. (Read more about this at Question 13.)

However, some people are **required** to enroll, including people who have Medicaid (Title 19), a Medicare Savings Program (QMB, SLMB or ALMB), Supplemental Security Income (SSI), and ConnPACE. People who qualify for Extra Help, a subsidy administered by the Social Security Administration that helps pay for Medicare prescription drug costs, will be automatically enrolled in a plan if they do not choose one on their own.

2. **How is the program administered?**

Medicare doesn’t administer the program directly. Instead, it contracts with private companies to provide the coverage. You need to enroll in a Medicare-approved prescription drug plan offered by one of these companies in order to have coverage. If you enrolled in a plan during 2006, this Guide will tell you about the changes to the program in 2007.

In 2007, there will be 51 free-standing **PDPs** (prescription drug plans) offered in Connecticut. The PDPs just offer prescription drug coverage.

There are 24 **MA-PDs** (Medicare Advantage Prescription Drug Plans). MA-PDs, which may be HMOs or Private Fee For Service plans, offer hospital and medical coverage in addition to prescription drug coverage. MA-PDs are options for people who want to receive all of their health care under a single provider. Some of these plans only offer coverage in certain counties within Connecticut.

There are also 9 Medicare Special Needs Plans (**SNPs**). SNPs are MA-PD plans that have special rules for enrollment. They are all limited to people who have Medicare and Medicaid ("dual eligibles"). Some have other requirements, such as living in an institution or having certain chronic or disabling conditions. Most SNPs only offer coverage in certain counties within Connecticut.

Ask CHOICES for the Enrollment Guide that describes all of the Connecticut PDP, MA-PDs and SNPs in detail.

In addition to the PDPs, the MA-PDs and the SNPs, some employers may "wrap around" the Medicare program to offer the coverage through their retirement health plans. Read more about this later in this Guide.

3. **Do I have to apply for coverage or will I get it automatically because I'm on Medicare?**

Medicare prescription drug coverage is voluntary, so the decision to enroll is up to you. * If you want Medicare prescription drug coverage, you will need to enroll in a PDP or MA-PD in order to have coverage. However, if you don't enroll when you are first eligible to do so, and you decide to enroll later on, you MAY have a late-enrollment penalty and a waiting period for coverage.

Read more about this at Question 11.

* **NOTE:** The program is voluntary for most people. However, certain people are required to enroll. People who have Medicaid (Title 19), ConnPACE, a Medicare Savings Program or SSI are required to enroll. They will be randomly assigned to a plan if they do not enroll on their own. People who apply for and are granted the Extra Help Subsidy will also be assigned to a plan if they do not enroll in a plan on their own.

4. **What drugs does Medicare cover?**

Medicare covers most outpatient prescription drugs, insulin and insulin supplies, and "stop-smoking" drugs. Medicare-approved plans are required to offer a choice of at least two drugs in each of 146 categories of drugs. Medicare-approved plans are also required to cover substantially all drugs in the following six categories of drugs: anti-

depressants, anti-psychotics, anti-convulsants, anti-cancer, immuno-suppressants and HIV/AIDS.

Certain drugs are not covered by any of the Medicare prescription drug plans. These “excluded” drugs include: barbiturates, benzodiazepines, drugs exclusively for weight loss or gain, over-the-counter drugs, and drugs that are covered by Medicare Part A or Part B.

Each Medicare prescription drug plan offers its own selection of Medicare-covered drugs, called a “formulary.” Each plan has a different formulary. **Your plan will only pay for Medicare-covered drugs that are on its formulary. Your plan will not pay for excluded drugs!**

Before deciding on a plan, you should carefully review its formulary to be sure that it covers all of the medications that you take. You should also look at the co-pay amounts of each of your drugs (because co-pay amounts vary for different types of drugs) and you should ask if any of your drugs are subject to utilization management tools, such as prior authorization, quantity limits and step therapy. These restrictions may make it more difficult for you to get your drugs.

5. **How do I pay for drugs that my plan doesn’t cover?**

If you need a drug that is not on your plan’s formulary, or if your plan is denying a drug because of utilization management restrictions, you can request an Exception from your plan to have this drug covered. You can also ask for an Exception to have a drug that you need reduced to a lower and less expensive tier. You will need your doctor’s written support

to obtain an Exception from your plan. Ask CHOICES about the Exception process.

Some drugs are **excluded**, i.e., Medicare doesn't cover them, and so they are not on any plan's formulary. Unless you are eligible for Medicaid or ConnPACE, you will need to pay for excluded drugs out of your own pocket. Furthermore, the purchase of excluded and non-formulary drugs generally will not count toward your "TrOOP" (true-out-of-pocket) spending requirement. (Read more about this at Questions 6 and 7.)

6. **How does the "standard benefit" work?**

Different plans offer different benefit structures, but in general the standard benefit will work as follows.

You will pay a monthly premium. The premium can be deducted from your Social Security check, or the plan can debit your bank account each month, or you can pay the plan directly. In 2007, PDP premiums in Connecticut range from about \$13 to \$87 per month. MA-PD premiums range from \$0 to about \$159 per month.

Some plans have annual deductibles and all plans have co-pays or co-insurance (amounts you are responsible to pay for each prescription). Most plans have "tiered" co-pays, i.e., the co-pay amount varies with the type of drug. (Generally, Tier 1 = generic drugs; Tier 2 = preferred brand; Tier 3 = brand; Tier 4 = specialty drugs.) Ask CHOICES for a listing of the

PDP and MA-PD plans in Connecticut. This listing also shows the plans' premiums, deductibles and co-pay amounts for different tiers of drugs.

- In 2007, the deductible cannot exceed **\$265** per year. (Many plans have a reduced deductible or no deductible.) If your plan has a deductible you will need to pay this amount before your coverage begins.
- After you have met your deductible, you enter the "Initial Benefit Period." Medicare pays 75% of each prescription and you pay 25% of the next \$2,135 in drug costs. In a standard plan, the most you will pay during the Initial Benefit Period is **\$533.75** (25% of \$2,135). (NOTE: most plans have tiered co-pays instead of 25% co-insurance during the Initial Benefit Period.)
- The next period is a Coverage Gap sometimes called the "donut hole." If your chosen plan has a coverage gap, you will pay 100% of all prescriptions until you have spent another **\$3,051.25** out-of-pocket. (In 2007, 15 plans pay for generic drugs during the donut hole; there are no plans that pay for brand name drugs during the donut hole.)
- Once you have spent a total of **\$3,850 (\$265 + \$533.75 + \$3,051.25)** in allowable "true out-of-pocket costs" ("TrOOP"), you will be eligible for "Catastrophic Coverage." For the remainder of the calendar year, Medicare will pay 95% of your prescription drug costs and you will pay only 5% of each prescription, or a \$2.15 or \$5.35 co-pay, whichever is greater.

7. **What are allowable out-of-pocket costs?**

As explained above, once you have spent \$3,850 in allowable true out-of-pocket costs, you will have met your TrOOP requirement and you will qualify for Catastrophic Coverage. For the rest of the year, Medicare will pay 95% of your prescription drug costs. **It is important to know that only certain payments count toward meeting the \$3,850 TrOOP requirement!**

- Payments that you make (or payments made by your family or by a charitable group) for drugs that are on your plan's formulary count toward meeting the \$3,850. Payments made by a State Pharmaceutical Assistance Program (like ConnPACE), also count toward TrOOP.
- Premium payments, payments made by Medicare or other insurance, payments made for drugs that are not on your plan's formulary, and payments for drugs purchased outside the United States, do **NOT** count toward the \$3,850 TrOOP requirement.

8. **Can I get “Extra Help” to pay for Coverage?**

If your countable income is below \$14,700 (single) or 19,800 (couple) ⁽¹⁾ and your countable assets (not including your house, car or certain types of savings) are below \$10,000 (single) or \$20,000 (couple), you may qualify for Extra Help to pay for Medicare prescription drug coverage. Social Security estimates this help to be worth up to \$3,700

in 2007. This Extra Help will take the form of reduced premiums, deductibles and co-pays.

If you think you may qualify for Extra Help, contact Social Security at **1-800-772-1213**. TTY users should call 1-800-325-0778. You can also visit www.socialsecurity.gov on the web, or you can call CHOICES at 1-800-994-9422.

You may also be able to get help to pay for Medicare prescription drug coverage if you qualify for Medicaid, ConnPACE, SSI or a Medicare Savings Program (QMB, SLMB or ALMB). Ask CHOICES if you might qualify for one of these programs.

⁽¹⁾ These income limits will increase in early 2007 when the 2007 Federal Poverty Limit amounts are announced.

9. **What if the cost of Medicare coverage is more than I pay now for prescription drugs?**

If you now take only a small number of medications, or you have another form of prescription insurance, your current costs may be less than they would be under the standard Medicare prescription drug benefit. You still need to consider Medicare coverage because:

- You may need additional, more expensive medications in the future.

- You may have to pay a higher premium if you don't enroll when you are first eligible.
 - You may have a waiting period for coverage if you don't enroll when you are first eligible.
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10. **Can I keep my existing drug coverage through my employer or union?**

The answer to this question will depend on a few facts:

- You need to contact your plan's Benefits Administrator to find out if your employer is going to keep your retiree coverage the same or change it to work with Medicare prescription drug coverage. Employers have options as to how they can make their existing benefits work with Medicare. This information may help you decide if you can stay with your existing plan or if you should select a Medicare prescription drug plan for coverage.
- You need to find out if the coverage you have from your existing plan is considered "creditable coverage" (meaning is it, on average, as good as the Medicare prescription drug benefit?). If the answer is "yes," then you may stay with your existing coverage and do not need to select a Medicare plan at this time. However, if your existing coverage is not creditable you need to enroll in a Medicare plan in order to avoid paying an increased premium in the future.

11. **When will I pay a higher premium?**

If you don't have any prescription insurance, or if your insurance is not "creditable," you will pay a higher premium if you did not enroll during the initial open enrollment period (November 15, 2005 – May 15, 2006). Your premium will be 1% higher for each month you could have enrolled in a Medicare prescription drug plan but did not. The 1% penalty is based on the national average monthly premium and it is a lifetime penalty.

The 2007 national average premium is \$27.35. If you waited 7 months to join a plan your penalty will be \$1.91 ($.01 \times \$27.35 \times 7 \text{ months} = \1.91). This amount will be added to your premium every month during 2007. The amount of the penalty may change in future years, depending on the national average monthly premium amount and the length of time you waited to enroll.

If you decline Medicare prescription drug coverage because you have existing insurance that offers "creditable coverage" you will not have to pay a higher premium if you decide not to enroll right away. **However, if you lose that creditable coverage you must enroll in a Medicare plan within 63 days of losing your creditable coverage in order to avoid a higher premium and a possible waiting period for coverage.**

12. **How will I know if my existing coverage is creditable?**

All insurers, including employer-sponsored and union-sponsored retirement health plans, must send their members and dependents a "Notice of Creditable Coverage" by November 15, 2006. (The Notice may be included in your plan's annual enrollment information, rather than a separate notice.) The Notice will indicate whether their coverage is considered "creditable." A plan is considered to be creditable if it is actuarially at least as good as Medicare prescription drug coverage.

NOTE: "Medigap" policies are NOT considered creditable. VA, TRICARE, Federal Employee Health Benefits (FEHB), and State of Connecticut retiree policies, ARE considered creditable.

If your existing coverage is creditable, be sure to save your Notice of Creditable Coverage in case you need to produce it later on to avoid a late enrollment penalty if you lose your creditable coverage and need to enroll in a Medicare prescription drug plan.

Contact your plan's Benefits Administrator if you do not receive a Notice of Creditable Coverage by November 15, 2006.

13. What are my choices if my existing coverage is creditable (as good as Medicare prescription drug coverage)?

If your existing coverage is creditable, you will have three choices:

- You can decline Medicare prescription drug coverage and stay with your existing plan. You may wish to do this if the costs of your existing plan are less than the costs of Medicare prescription drug coverage, OR ...
- You can keep your existing coverage and enroll in a Medicare prescription drug plan to supplement your present coverage, **IF** your existing plan will allow you to do this without jeopardizing your existing coverage, OR ...
- You can drop your present coverage and enroll in a Medicare prescription drug plan. If you select this option you may not be able to rejoin your health plan if you later change your mind.

CHECK WITH YOUR PLAN'S BENEFITS ADMINISTRATOR BEFORE MAKING A DECISION!

14. **When can I enroll in a Medicare Plan?**

The initial enrollment period for Medicare prescription drug coverage was November 15, 2005 – May 15, 2006. In 2007 and beyond you can enroll between November 15 and December 31 of each year to have coverage effective January 1 of the following year. This is called the Annual Coordinated Election Period (ACEP), also known as the Annual Enrollment Period.

If you are new to Medicare, e.g., if you are just turning 65, your Initial Enrollment Period (IEP) consists of a 7-month period: 3 months before your 65th birthday, the month of your birthday, and 3 months after your 65th birthday. If you do not enroll during your Initial Enrollment Period you may have to wait until the next annual enrollment period and you may have a late enrollment penalty.

15. **Can I change plans?**

Yes, under these circumstances:

- If you belong to a PDP, you may change plans between November 15 and December 31 of each year. This is called the Annual Coordinated Election Period (ACEP). You can change plans more often if you qualify for a Special Enrollment Period (SEP). For example, you would qualify for a SEP if you permanently moved out of your plan's service delivery area. Ask CHOICES what other circumstances would qualify for a SEP.

NOTE: If you are changing plans, it is strongly recommended that you enroll in your new plan by December 8, 2006 to ensure that your new coverage begins on January 1, 2007!

- If you belong to an MA (without prescription coverage) or an MA-PD (with prescription coverage), you may change plans between January 1 and March 31 of each year. This is called the MA Open Enrollment Period (OEP). You can change more often if you qualify for a Special Enrollment Period (SEP). You cannot add or drop prescription drug coverage during this period. For example, if you are leaving a plan without prescription drug coverage, you can only enroll in a plan without prescription drug coverage. If you are leaving a plan with prescription drug coverage, you can only enroll in a plan with prescription drug coverage. You can also leave your MA or MA-PD plan and return to original Medicare, provided you do not change your prescription drug status. Ask CHOICES for more information.

16. **How do I choose a plan?**

You may be receiving information from many sources, including Medicare and various plans that offer coverage in your area. You need to study this information and ask the following questions at a minimum:

- Do you live in the plan's service area?
- How much is the monthly premium?
- Is there an annual deductible?
- Are your drugs on the plan's formulary?

- Are your drugs subject to utilization management tools?
- What are the tiered co-pay amounts for your drugs?
- Is the plan accepted at the retail or mail order pharmacy that you use?

If you spend part of the year in another state, you may want to consider one of the **national plans** with a wider preferred provider network. Refer to the CHOICES Enrollment Guide for more information about choosing a plan, and detailed information about the plans themselves.

17. **Do I have to do anything if I am happy with my existing plan?**

Before you decide whether to stay with your existing plan you need to find out if your plan will change in 2007! The way to find out is to study the information your plan will send you at the end of October in its Annual Notice of Change (ANOC).

The ANOC includes information about changes to premium and deductible amounts, changes in “donut hole” coverage, and changes to formularies, including the addition of utilization management tools such as prior authorization, quantity limits and step therapy on any of its formulary drugs. The ANOC also includes information about changes to tiered co-pay amounts, including the placement of drugs on a different tier.

<p>IMPORTANT: If a plan granted an indefinite Exception in 2006 that it does not intend to continue in 2007, the plan must notify the member of this</p>

change. This notice may be included in the ANOC or it may be sent in a separate notice mailed by the end of October.

If you remain satisfied with your plan after reading the ANOC you do not need to do anything. Your membership in the plan will automatically continue into 2007.

18. Important dates in late 2006 and early 2007.

Mid-October 2006 – Medicare’s on-line Plan Finder tool, which allows people to identify and compare PDPs and MA-PDs in their area, is updated with 2007 plan information. It also allows people to enroll in a plan on-line. To access the Plan Finder tool go to: www.medicare.gov.

End of October 2006 - Plans mail out their Annual Notice of Change (ANOC) informing members of any changes to premiums, formularies, cost-sharing, Extra Help subsidy status, and continuing exceptions for the coverage of non-formulary drugs.

Late October - early November 2006 - Medicare mailed the “Medicare & You 2007” Handbooks. The handbook provides general information about Medicare, including services covered by Medicare and the rights of Medicare beneficiaries. It also contains detailed information about PDPs, MA-PDs and SNPs available in your geographic area.

November - Medicare notified people who were randomly assigned to a plan in 2006 if they were being reassigned to another benchmark plan.

Mid-November 2006 - Employers and unions that provide benefits to Medicare-eligible individuals and dependents must provide members with notice, before November 15, whether the prescription drug coverage they offer is “creditable,” i.e., whether it is at least as good as the Medicare prescription drug program.

November 15, 2006 – December 31, 2006 - The Annual Coordinated Election Period. Medicare-eligible individuals can enroll in or change their PDP. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their PDP for the rest of the calendar year.

December 8, 2006 – The date by which people who wish to change plans should enroll in their new plan in order to ensure coverage by January 1, 2007.

January 1, 2007 - New Medicare prescription coverage begins for 2007.

January 1, 2007 – March 31, 2006 - The MA Open Enrollment Period. Medicare-eligible individuals can change their MA or MA-PD plan. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their MA or MA-PD plan for the rest of the calendar year. People cannot add or drop prescription drug coverage during this period.

19. **Where can I get more information?**

Call **CHOICES** at **1-800-994-9422** to speak to a counselor at the Area Agency on Aging serving your area of the state. CHOICES counselors are trained and certified to assist you with your Medicare issues and concerns. They can also help with comparing and enrolling you in a Medicare prescription drug plan and getting Extra Help to pay for your premiums, deductibles, and co-pays.

You can also get more information from these on-line sources:

- State of CT, Department of Social Services: www.ct.gov/Medicarerx
- Medicare: www.medicare.gov
- Social Security: www.socialsecurity.gov
- Center for Medicare Advocacy: www.medicareadvocacy.org
- Department of Social Services, Aging Services Division:
www.ct.gov/agingservices

CHOICES is a program of the State of Connecticut Department of Social Services, Aging Services Division, and serves as Connecticut's State Health Insurance Assistance Program (SHIP), as designated by the Centers for Medicare and Medicaid Services. CHOICES is administered in partnership with the Area Agencies on Aging and the Center for Medicare Advocacy, Inc.



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This publication is not a legal document. The official Medicare provisions are contained in the relevant laws, regulations and rulings.

This information is available in alternative formats. Call 1-800-994-9422. TDD/TTY users call 1-800-842-4524.